

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PRC

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

111a

07079

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County GarrettCity or town Oakland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County GarrettCity or town Oakland
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mary Cecelia Harsch

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

female white single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 17, 18928. AGE: Years Months Days If less than one day
54 8 5 hrs. min.9. Birthplace Fulda Minn.
(Town, county, and state)10. Usual occupation Chief telephone operator11. Industry or business Local office for 36 years12. Name Matthew Harsch13. Birthplace Germany14. Maiden name Julia Shaffer
Nr. Oakland, Md.

15. Birthplace

16. Informant Richard Shaffer
Address Oakland, Maryland17. Buried Date thereof Aug. 26, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Peters Rem.Location Oakland, Md.18. Funeral director Emroy D. BoldenAddress Oakland, Md.19. 89 26-47 19. Julia A. Rowan
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 22, 1947 19. 22 at 9:20 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

about a month 19. 47 to Aug. 22 19. 47
and that I last saw h. er alive on dead August 22 19. 47

Immediate cause of death

Pulmonary EmbolismCoronary thrombosis

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. I. Baumgartner
** Signature of physician E. I. M. BaumgartnerAddress 25 Alder St. Date signed 9/1/47
S. J. Rowan

SEP 18 1947
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 172

07080

1. PLACE OF DEATH
County Garrett
City or town Shallmar
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr. 2 mon.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Garrett
City or town Shallmar
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3.(a) FULL NAME Stelman Lester Hedrick

3.(b) Social Security Number

234-26-9814

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Minnie Lucille (Maule) Hedrick
8.(c) If alive, give age 19 years
7. Birth date of deceased (mo., day, yr.) Jan. 28, 1906
8. AGE: Years 41 Months 6 Days 8 If less than one day _____ hrs. _____ min.

9. Birthplace Whitmar, Randolph Co., W.Va.
(Town, county, and state)
10. Usual occupation Woodsman & Miner Coal Mines

11. Industry or business
12. Name George Hedrick
13. Birthplace Wango, Pendleton Co., W.Va.
14. Maiden name Bertha Simmons
15. Birthplace Whitmar, Randolph Co., W.Va.

16. Informant Mrs. Minnie Hedrick
Address Shallmar, Md.

17. Burial Aug. 7, 1947
(Burial, cremation, or removal. Which?) Date thereof _____ (month) (day) (year)
Cemetery or crematory Whitmar Cemetery
Location Whitmar, W.Va.

18. Funeral director Otha F. Sharpless
Address Blaine, W.Va.

19. Aug 8 47 C. W. Berrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 6 47 at 3:30 A.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1947 to Aug 6 1947 and that I last saw him alive on Aug 6 1947
Immediate cause of death _____

Due to Acute myocarditis
Due to Coronary Vascular Disease
Other conditions None
(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work?

23. SIGNATURE Ralph Culanville M.D.
Address Kitzinger, Md. Date signed Aug 7-47

RECEIVED
SEP 13 1947
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The coroner is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 168

1. PLACE OF DEATH:

County... **Garrett**City or town... **R. F. D., Frostburg**
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

ALBERT BERNARD KLINK

3. (b) Social Security Number

none

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Virginia Klink

7. Birth date of deceased (mo., day, yr.)

June 3, 1869

6. (c) If alive, give age

56 years

8. AGE:

Years

78

Months

2

Days

27

If less than one day

hrs.

min.

9. Birthplace

Garrett county, Maryland

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

FATHER

12. Name

Bernard Klink

13. Birthplace

unknown

MOTHER

14. Maiden name

"

15. Birthplace

"

16. Informant

Mrs. Albert Klink,

Address

Frostburg, Md.

17.

Burial

(Burial, cremation, or removal, Which?)

Date thereof... **Sept. 3, 1947**
(month) (day) (year)

Cemetery or crematory

Johnson Cemetery,

Location

Garrett County, Md.

18. Funeral director

J. R. Durst,

Address

Frostburg, Md.

19.

Sept. 3, 1947
(Date rec'd by registrar)**Mr. Julius Michael**
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... **Maryland** County... **Garrett**City or town... **R. F. D., Frostburg**
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH... **Aug 31, 1947** at **7:20 P.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1940 to **Aug 31, 1947**and that I last saw him alive on **Aug 31, 1947**

Immediate cause of death

Chronic myocarditis

DURATION

2 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John Lane
Address... **Frostburg, Md.** Date signed... **Sept 3, 1947**

RECEIVED

SEP 6 1947

BUREAU V B

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 166

1. PLACE OF DEATH:

County Garrett
City or town Mt. Lake Park Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County GarrettCity or town Rural Deer Park Rt. 1
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Infant Mc Intosh

3. (b) Social Security Number

4. Sex

Male white

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife Elizabeth TichnellMcIntosh

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

Aug. 14, 1947

8. AGE:

Years

Months

Days

If less than one day

1 hrs.

min.

8. Birthplace

Mt. Lake Park Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof Aug 15, 47
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19.

47

Julia A. Rowan

Local

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14, 1947 at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19____, to _____ 19____

and that I last saw him _____ alive on _____ 19____

Immediate cause of death

Pneumonia - 6 wks.
Birth

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work?

23. SIGNATURE

A. E. Mann
MD

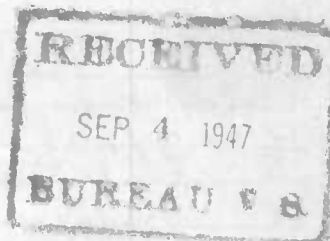
M. D. or other

Address Oakland MdDate signed 15 Aug 47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

07083

CERTIFICATE OF DEATH

Reg. Dist. No. 161

1. PLACE OF DEATH:

County Garrett
 City or town near Friendsville
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Garrett
 City or town near Friendsville
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Stella Blanche Selby Hennigh Oher

3. (b) Social Security Number

4. Sex F 5. Color or race W. 6. (a) Single, married, widowed, or divorced Widow

8. (a) Name of husband or wife Jan 25 - 1881
 Birth date of deceased (mo., day, yr.) Jan 25, 1881
 8. (c) If alive, give age 47 years

8. AGE: Years 66 Months 7 Days _____ It less than one day _____ hrs. _____ min.

9. Birthplace Selbyport Md
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business _____

12. Name William C Selby13. Birthplace Md14. Maiden name Malison Stafford15. Birthplace Md16. Informant Horace HennighAddress Friendsville Md

17. (Burial, cremation, or other. Which?) Aug 27 - 47
 Date thereof (month) (day) (year)

Cemetery or _____

Location Friendsville Md18. Funeral director H. H. SavageAddress Friendsville Md19. Aug 27, 47 Kathryn Fite

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25 19 47, at _____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19 46 to Aug 1st 19 47
 and that I last saw her alive on Aug 4 19 47

Immediate cause of death chronic myocarditis
 DURATION 1 year

Due to _____

Due to _____

Other conditions Diabetes mellitus 20 years

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Milton Jeffer MD
 M. D. or other

Address FRIENDSVILLE, MD. Date signed Aug 27, 1947

OFFICE OF THE SECRETARY OF THE ARMY

MEMORANDUM FOR THE SECRETARY OF THE ARMY

MEMORANDUM FOR THE SECRETARY OF THE ARMY

RECEIVED
AUG 30 1947
BUREAU OF THE ARMY

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

07084

CERTIFICATE OF DEATH

Reg. Dist. No. 166

1. PLACE OF DEATH:

County Garrett
City or town Oakland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 29 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution? -----

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Garrett

City or town Oakland
(If outside city or town limits, write RURAL and give nearest town)

Street No. -----
(If rural, give LOCATION)

2.(a) If veteran, name war -----

3. (a) FULL NAME

Anna E. Murphy Smouse

3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Widowed

6.(b) Name of husband or wife Edward H. Smouse

6.(c) If alive, give age ----- years

7. Birth date of deceased (mo., day, yr.) June 19, 1875

8. AGE: Years Months Days If less than one day
72 1 18 ----- hrs. ----- min.

9. Birthplace Garrett Co., Md.
(Town, county, and state)

10. Usual occupation House Wife

11. Industry or business Own Home

12. Name William Murphy

13. Birthplace Garrett Co., Md.

14. Maiden name Ellen Enlow

15. Birthplace Garrett Co., Md.

16. Informant Ellen Smouse Sefeld

Address Oakland, Md.

17. Burial Date thereof Aug. 7, 1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Oakland Cemetery

Location Oakland, Md.

18. Funeral director Herbert C. Leighton

Address Oakland, Maryland.

19. 8/7/ 47 Julia A. Rowan

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 5, 19 47 at 3:15P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

November 19 45 to August 19 47

and that I last saw her alive on August 5 19 47

Immediate cause of death -----

Myocarditis Chronic 8 yrs

Due to Auricular Fibrillation 8 yrs

Due to Arteriosclerosis 97

Other conditions -----

(Include pregnancy within 3 months of death)

Major findings of operations -----

Date of op. -----

Autopsy results -----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ----- Date of -----

Where did injury occur? ----- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -----

Means of injury ----- Injured at work? -----

23. SIGNATURE A. E. Mance M.D.

Address Oakland, Maryland Date signed 8-7-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 13 1947

BUREAU 9 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Line correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

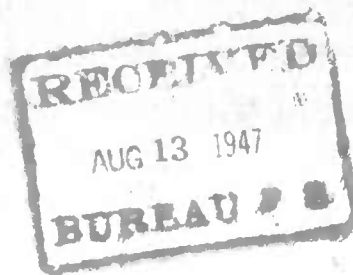
CERTIFICATE OF DEATH

Reg. Dist. No. 13/a 07085 166

1. PLACE OF DEATH: County <u>Garrett</u> City or town <u>Mt. Lake Park</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>27 yrs.</u> Hospital, institution, or street address where death occurred: _____ How long in hospital or institution? _____				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Garrett</u> City or town <u>Mt. Lake Park</u> (If outside city or town limits, write RURAL and give nearest town) Street No. _____ (If rural, give LOCATION) 2.(a) If veteran, name war _____			
3. (a) FULL NAME <u>Emma King Stottlemeyer</u>				3. (b) Social Security Number _____			
4. Sex <u>Female</u>		5. Color or race <u>White</u>		6. (a) Single, married, widowed, or divorced <u>Widowed</u>			
6. (b) Name of husband or wife <u>Sheridan Stottlemeyer</u>							
7. Birth date of deceased (mo., day, yr.) <u>January 17, 1872</u>							
8. AGE: Years <u>75</u> Months <u>6</u> Days <u>22</u> If less than one day _____ hrs. _____ min.		6. (c) If alive, give age _____ years					
9. Birthplace <u>Grant Co., W. Va.</u> (Town, county, and state)							
10. Usual occupation <u>House Wife</u>							
11. Industry or business <u>Own Home</u>							
12. Name <u>John B. King</u>							
13. Birthplace <u>Garrett Co., Md.</u>							
14. Maiden name <u>Sarah Yokum</u>							
15. Birthplace <u>Virginia.</u>							
16. Informant <u>Charles Stottlemeyer</u> Address <u>Mt. Lake Park, Md.</u>							
17. Burial Date thereof <u>Aug. 9, 1947</u> (Burial, cremation, or removal, Which?) (month) (day) (year) Cemetery or crematory <u>Oakland Cemetery</u> Location <u>Oakland, Maryland.</u>							
18. Funeral director <u>Herbert C. Leighton</u> Address <u>Oakland, Maryland</u>							
19. <u>8/9/</u> <u>47</u> <u>Julius A. Rowan</u> (Date rec'd by registrar) _____ Registrar							
MEDICAL CERTIFICATION 20. DATE OF DEATH <u>August 7,</u> <u>47</u> at <u>1:30P.</u> M 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>July 3rd</u> <u>47</u> to <u>August 7th</u> <u>47</u> and that I last saw h. <u>er</u> alive on <u>8-7-47</u> Immediate cause of death <u>Bronchial Pneumonia</u> <u>2 days</u> DURATION Due to <u>Heart Failure</u> <u>5 days</u> Due to <u>Chronic Nephritis</u> <u>years</u> Other conditions _____ (Include pregnancy within 3 months of death) Major findings of operations _____ Date of op. _____ Autopsy results _____ PHYSICIAN: Please underline the cause to which death should be charged statistically. 22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide _____ Date of _____ Where did injury occur? _____ (City or town) (County) (State) Injured at home, farm, industry, public place (where?) _____ Means of injury _____ Injured at work? _____ 23. SIGNATURE <u>Robert B. Sothern M.D.</u> <u>Oakland, Md.</u> M. D. or other <u>8-8-47</u> Address _____ Date signed _____							

Miss Julia
unable to locate Arthur J. Jones.

Must leave on an emergency ambulance case.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Wolverton

CERTIFICATE OF DEATH

Reg. Dist. No. 163

07086

93d

1. PLACE OF DEATH:

County GarrettCity or town Bloomington
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 25 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County GarrettCity or town Bloomington
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2(a) If veteran, name war _____

3. (a) FULL NAME

Edward Ellsworth Warnick

3. (b) Social Security Number

212-24-11864. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced Widower6. (b) Name of husband or wife Cara Wright Warnick7. Birth date of deceased (mo., day, yr.) September 26, 18718. AGE: Year 75 Months 10 Days 20 It less than one day _____ hrs. _____ min.9. Birthplace Bloomington - Garrett - Maryland
(Town, county, and state)10. Usual occupation Miner11. Industry or business Coal - Mine12. Name Henry Warnick13. Birthplace Bloomington, Md14. Maiden name Mahalia Jenkins15. Birthplace Not known16. Informant Gertrude JeffriesAddress Kuper, W. Va17. Burial Date thereof Aug 20, 1947
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Oakland CemeteryLocation Oakland, Md18. Funeral director Ellsworth SchoolAddress Westport, Md.19. Aug 20 1947 Dorsey Patton
(Date read by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 17 1947 at 8:35 p.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 10 1947 to Aug 17 1947and that I last saw him alive on Aug 17 1947

Immediate cause of death _____ DURATION

Myocardial Degeneration. 3moDue to Myocarditis. 1yr

Due to _____

Arterio Sclerosis. 5yrsOther conditions Miners Asthma, 10 yrs

(Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Sam'l R. Smith, M.D. M. D. or otherAddress Piedmont W Va Date signed 8/18/47

RECEIVED

AUG 23 1947

BUREAU F B